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MENTAL ILLNESS AND THE MIND-BRAIN PROBLEM: DELUSION, BELIEF AND SEARLE'S THEORY OF INTENTIONALITY

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ABSTRACT. Until recently there has been little contact between the mind-brain debate in philosophy and the debate in psychiatry about the nature of mental illness. In this paper some of the analogies and disanalogies between the two debates are explored. It is noted in particular that the emphasis in modern philosophy of mind on the importance of the concept of action has been matched by a recent shift in the debate about mental illness from analyses of disease in terms of failure of functioning to analyses of illness in terms of failure of action. The concept of action thus provides a natural conduit for two-way exchanges of ideas between philosophy and psychiatry. The potential fruitfulness of such exchanges is illustrated with an outline of the mutual heuristic significance of psychiatric work on delusions and philosophical accounts of Intentionality.

Key words: connections philosophy and psychiatry, belief, delusion, intention, mind-brain problem, psychopathology, rationality, reason

INTRODUCTION

The relative stand-off between philosophy and psychiatry [1, 2] is nowhere more remarkable than in the debate about mind and brain. This is remarkable, first, for the number of topics which the two disciplines have in common. There have been some important recent publications – on personal identity [3–6], on knowledge of other minds [7], on rationality [8]. But cross-border studies remain the exception rather than the rule. The stand-off is still more remarkable however for the fact that the whole debate in philosophy about the nature of mind has been matched by a debate in psychiatry about the nature of mental illness. Yet the mind-brain debate has proceeded largely without reference to the phenomenology of mental illness; while references to the mind-brain debate in the debate about mental illness have generally been restricted to the refutation of dualism, this being adduced equally by supporters [9] as by opponents [10] of the concept of mental illness.

In this paper, then, an attempt is made to bring these two debates closer together. Recent trends in the debate about mental illness are outlined and

certain parallels are drawn with the debate about mind and brain. These parallels could be merely superficial, of course. We will indeed find that there are disanalogies as well as analogies. Nonetheless the parallels provide a framework for a two-way exchange of ideas between philosophy and psychiatry. This is illustrated with a brief exploration of the way in which Searle's [11] account of the Intentionality of belief could help to illuminate the clinical concept of delusion, and correspondingly how the descriptive psychopathology of delusions could be used to test and extend Searle's theory of belief.

MENTAL ILLNESS

The debate about mental illness has traditionally been pursued by comparing and contrasting mental illness with physical (or bodily) illness ([12], ch.1). This has been true both of those who are 'against' the concept of mental illness (generally anti-establishment figures, from a medical point of view) and of those who are 'for' it (generally establishment figures). Thus Szasz [10] argues that mental illness is essentially different from physical illness: where physical illness is defined by objective norms of bodily structure and functioning, mental illness is defined by value-laden criteria of social functioning. This is the basis of his conclusion that mental illness is a myth. On the other side in the debate, however, the supporters of mental illness have taken the line that the evaluative connotations of mental illness are merely superficial. Kendell [13], Boorse [14] and others, argue in effect that physical illness is defined by the presence of physical disease, which in turn is defined by objective criteria of 'biological' functioning – reduced life and/or reproductive capacities. By these criteria, they suggest, mental illness, too, can be defined in terms that are value-free.

This traditional form of argument, whether it is run for or against mental illness, is underpinned by two (more or less tacit) assumptions: that the concept of physical illness is relatively unproblematic compared with mental illness; and that its meaning is to be understood in terms of a scientific paradigm of disease defined by value-free criteria of disturbed functioning. These assumptions, moreover, make the outcome of this form of argument, again whether for or against mental illness, inherently reductionist. The validity of mental illness depends on whether or not it can be moulded to fit the paradigmatic physical disease. If the differences are considered too great, then it does not exist. But if the differences are merely superficial, then it is really physical illness after all.

However the way in which the argument in this form actually proceeds belies the assumptions on which it depends. For the argument turns on the view which is taken of the meaning, not of mental illness, but of physical illness. To this extent then, it is not the meaning of mental illness which is problematic but

rather than of physical illness. This in turn undermines the assumption of a scientific paradigm of physical disease. And this leads to a quite different form of argument from the reductionism implicit in the traditional approach. For now mental illness and physical illness are on an equal footing, conceptually speaking. Hence the form of argument which it is natural to adopt is not one of reduction – either of mental illness to physical or of physical illness to mental – but rather one of generalization. Mental illness and physical illness could still turn out to be conceptual species of essentially different kinds (the equivalent of Szasz's conclusion). But what is involved in establishing the validity of mental illness is that it and physical illness are shown to be equally valid subspecies of the general concept, illness, species which are legitimately different in some ways and similar in others.

From a philosophical perspective this inversion of the traditional form of argument should come as no surprise. It is well recognized philosophically that concepts may be unproblematic in use (like physical illness) despite, rather than in consequence of, transparency of meaning – consider the concept of time, for example. Moreover it is the guiding principle of the linguistic-analytical method that use may be a better guide to meaning than received definition [15]. Hence recent work on the concept of illness and disease has taken seriously and exploited, rather than arguing away, the *prima facie* evaluative nature of these concepts. This leads to a picture of the conceptual framework of medicine in which the patient's subjective experience of illness, rather than the doctor's medical knowledge of disease, is logically primary ([12], ch. 5; [16]), and in which this experience is analysable in terms of incapacity, of loss of agency or defective action, rather than of defective functioning ([12], ch. 7; [17]). This is not anti-scientific. In the past sociological and anthropological work on the importance in medicine of value judgements [18] and loss of agency [19] has been perceived as being in opposition to the scientific "medical" model. But philosophical work in this area gives us instead a more complete picture of the conceptual framework of medicine, one in which the elements of value, of the experience of illness, and of failure of action are emphasised alongside the elements of fact, disease and failure of function. We will be looking at an example of the heuristic potential of this more complete view in the concluding section. But we must turn first to the possible parallels between the debate about mental illness and the debate about mind and brain.

MIND AND BRAIN

One obvious parallel between the debate about mental illness and the mind-brain debate is that there are two sides. In the mind-brain debate, it is true, the two

sides are less clearly distinct. But in this debate, as in the mental illness debate, there are believers and non-believers, those who (essentially) believe in mind and those who (essentially) do not. Again, there is a difference in that in the mind-brain debate the dominant or orthodox view has fluctuated over time. In recent years the balance, in contrast to the mental illness debate, has been with the non-believers. As Searle has put it, so concerned have most writers on the mind-body problem been to avoid dualism that – echoing Szasz on mental illness – they have in effect denied that “there really are such things as intrinsic mental phenomena which cannot be reduced to something else or eliminated by some kind of re-definition” ([11], p. 282). This was perhaps clearest with philosophical behaviourism. Ryle’s campaigning enthusiasm for eliminating the pejorative ‘ghost in the machine’ [20] has much of the later campaigning enthusiasm of Szasz and others for eliminating mental illness from medicine. But there is something of it, too, in modern functionalist theories. For functionalists mind is (with more complication, but still *merely*) the enactment of a software programme mediating appropriate causal connections between the organism and the environment. Functionalism is consistent with physicalism and it thus accommodates those features of mind that link it with body – spatio-temporal location, dependence on the structural and functional integrity of the brain, emergence (both in individual development and evolution) from the organization of matter in particular ways, and so on. Moreover, it is less obviously a reductionist theory of mind. It provides for a degree of looseness in the causal connections between brain states and mental states [21]; its ‘software’ allows it to capture the representational properties of mind; and this software, as Boden [22] has argued, mechanistic though its embodiment must be, is capable in principle of computing beliefs, desires and other ‘warm-blooded’ mental phenomena, as well as the colder cognitive processes (orientation, memory, problem solving, pattern recognition) currently studied by computer scientists and cognitive psychologists. But for all this there is a great deal that is not captured by theories of this kind. As McGinn [23] and others have pointed out, there is no more room in a computer programme than there was in behaviour for many of the very features of mind that make it mental – subjectivity, freedom, and, not least, consciousness itself.

It is an awareness of something ‘left out’ in these theories that lies behind the arguments of those on the other side in the mind-body debate, those who, essentially, believe in mind. The rise of cognitive psychology has been associated with a reassertion of the reality of psychological processes, subconscious as well as conscious, with real causal properties. But among philosophers, Nagel, in particular, has emphasised the uniqueness and irreducibility of the subjective point of view as the defining characteristic of the mental [24]. The shift of emphasis here from brain processes, whether constitutive or merely

formal, to conscious experience, thus parallels the shift in recent work on the medical concepts from disease to illness, from the doctor's knowledge of disease processes to the patient's experience of illness.

This could be another superficial parallel of course. But the two shifts reflect a similar underlying concern, to restore the primacy of persons. And this leads to a further and as we will find significant parallel – the increased prominence in the philosophy of mind, as in work on the medical concepts, on the concept of action. Performing actions, rather than functioning, is the characteristic way in which people, and other beings to whom we attribute consciousness, do things. These two concepts – 'action' and 'function' – are of course closely related conceptually. But it is people's actions, bodily and/or mental, not the functioning of their bodily or mental parts or systems, which may or may not be conscious, just as it is failure of action, bodily and/or mental, rather than some underlying change of bodily or mental functioning, which is at the heart of the experience of illness. Strawson's emphasis on the logical primacy of persons [25] thus parallels the corresponding medical emphasis on the primacy of the patient. Similarly, Wiggins's argument that 'living body' is abstracted from 'person', parallels the derivation of concepts of bodily disease from the patient's experience of illness [26].

A non-reductionist stance also leads to a parallel in outcome criteria. In the debate about mental illness, both supporters and opponents of the concept have in the past adopted a reductionist form of argument, emphasising respectively the similarities and differences between it and physical illness: whereas, as we saw earlier, a non-reductionist form of argument requires an account of both, of both similarities *and* differences. McGinn ([23], ch. 2) has argued similarly about the mind-brain debate. He points out that most of the solutions which have been proposed for the mind-brain problem have been reductionist, either of mind to body or (with idealism) of body to mind. But what is needed, he says, is a theory which does justice equally to both, a theory which accounts for both the similarities and the differences between them.

Despite all these similarities, however, there remains an important difference between the two debates, namely in their underlying assumptions. In the debate about the medical concepts there is no longer an assumption that mental illness, because problematic in use, is somehow *the* problem when it comes to questions of definition. But in the mind-brain debate there is still a widely-held assumption that, as between mind and brain, it is mind which is the more obscure, mind which is in most need of justification and analysis.

This is apparent, first, in the way the arguments even of those who believe in mind are formulated. There is a certain defensiveness in their position, a sense of the rear-guard action. Searle, for example, defends semantics by a thought experiment designed to show what it is not; that it is not syntax [27]. More

generally, it is the existence of other minds, not bodies, which is taken to be problematic. But the assumption that mind is the problem is even more clearly apparent in the positive theories that have been offered. For these have almost invariably involved bodily images or material metaphors. Descartes, in a sense the original non-reductionist, wrote of mental 'substance', and of body and mind in causal interaction by way of the pineal gland. Among his successors, too, we find parallel ticking clocks, creators lighting blue touch papers, and epiphenomenal froth. In modern theories the relative 'givenness' of the body is evident in a tendency to rely directly or indirectly on the assumed authority of science. Dennett openly acknowledges science as his model [28]. Even Searle, after a forthright defence of the reality of the mental, sums up his own view as being that mental states are "as real as any other biological phenomena", calling his position "biological naturalism" ([11], p. 264). Yet as Nagel has pointed out [24], the invention of a new element of objective reality for the purpose of capturing mind, cannot, logically cannot, work. For to the extent that it is successful it must exclude the essential subjectivity of the mental. Though even Nagel, in an earlier paper [29], looked to what he called a "more objective" understanding of the mental as a way of closing the gap between subjective and objective points of view.

Up to a point this amounts to no more than a reiteration of Wittgenstein's observation that philosophy generally has been too much influenced by the natural scientific point of view [30]. In medicine, however, a recognition of the limitations of an exclusively scientific model of illness and disease, has gone with the claim that there is an evaluative as well as descriptive logical element woven into the meanings of the medical concepts. There are a number of reasons for being cautious in extending this claim to mind and brain. In the case of the medical concepts, notwithstanding the importance of science in medicine, there were always clear signals of their evaluative natures. Mental illness is overtly value-laden and even physical illness and disease are etymologically value terms. With mind, too, there are signals of a kind. Moral freedom, notably, is a key mental feature. But it stands in contrast to the deterministic 'body': and it has at least no surface connections with other key mental features such as subjectivity and consciousness. The suspicion must arise, therefore, that the evaluative element in medicine derives from the illness in mental illness, as it were, not from the mind.

We should not be *too* cautious in extending the claim, however. What Dennett calls "normative" theories of mind [31], have, after all, an established if not very prominent place in philosophy, as indeed have theories of related concepts such as rationality and person – Locke thought person to be a "forensic" concept ([32], bk II, ch. XXVII). Certain recent theories of mind, in addition, sometimes seem to imply an evaluative element without naming it as such – Davidson's

'pro-attitudes', for example [33]. Moreover, the link with the medical concepts may be closer than it appears at first sight. For intention, as Anscombe argued, is an evaluative concept [34]. In action-failure theories of the medical concepts this allows specifically medical (as distinct from moral or aesthetic) value to be derived from the negative value implicit in failure of intention ([12], ch.7). Hence to the extent that the concept of intention is integral to that of action, which in turn is integral to the concept of mind, so an evaluative element of meaning may turn out to be integral as much to mind as to mental illness.

DELUSION AND BELIEF

In this section the potential for a two-way exchange between philosophy and psychiatry will be illustrated for just one of the parallels outlined above – the shift in both psychiatry and philosophy of mind to an emphasis on the concept of action; and for just one area of mutual interest – delusion (a key symptom of mental illness) and belief (a key topic in the philosophy of mind).

On first inspection delusions appear to make a good case for the conventional science-based view of mental illness. Underpinning as they do all other psychotic symptoms – in which patients characteristically 'lack insight' into their condition – they have long been identified as the paradigm symptom of mental disorder [35]. They are identifiable in practice as reliably as any symptom of physical illness; and this, consistently with the standard view, appears to correlate with the availability of a straight-forwardly 'scientific' definition of the term. Most medical text books offer no definition of mental illness. But delusion is defined standardly as "A false belief, held despite evidence to the contrary, and one which is not explicable in terms of the patient's educational and cultural background. It is held with complete conviction and cannot be shaken by argument" [36]. A number of authors, in psychology [37] as well as philosophy [38], have pointed out weaknesses in this definition: not all delusions are culturally atypical, conviction is no mark of pathology, and so on. But the central idea of delusion as a false belief has seemed to put it on as 'objective' a footing as the symptoms of physical illness ([39], part I).

Closer examination shows however that the standard definition is inconsistent with the actual use which is made of the concept clinically. Delusions are indeed sometimes false beliefs, often bizarrely so, but they are not always or necessarily so. They may be true beliefs, not just coincidentally, but actually known to be true (in the sense of being concordant with fact) at the time the diagnosis is made [40]: similarly, they may be, in the terms of the standard definition, paradoxical – the patient with the delusion of mental illness ([12], ch. 10): and

they may not be beliefs at all, at any rate as to matters of fact, but value judgements [41].

These glaring inconsistencies between the standard definition and the use which is made of the concept clinically, have not been widely noted. This in itself is of interest philosophically. It reflects the fact that the *logical* form of a delusion – whether it is an assertion of fact, true or false, or a value judgement, negative or positive – makes no difference to the treatment the patient receives. It is well recognised clinically that it is not the content (guilt, impoverishment, grandiosity, persecution etc.) that makes a delusion pathological, but its form [42]. What is shown by the present considerations is that it is not the logical form of a delusion that is material but a background structure of meaning within which it is embedded. By analogy with the classical paradox of the liar, the paradoxical delusion of mental illness shows this directly. It is also shown indirectly by the observation that factual and evaluative delusions, though so distinct logically, should have identical implications for treatment [41].

From a conventional scientific point of view, these philosophical considerations may seem to point to no more than that delusions should be considered not as false but as unfounded beliefs, the implication being that they are based on some disturbance of cognitive functioning as the requisite lack of foundation. But despite extensive effort, no disturbance of cognitive functioning – of memory, attention, general intellect, and so forth – that is characteristic of delusions has yet been identified [37]. Delusions occur in conditions in which such disturbances are to be found: in dementia, for example, and in hypomania. But these conditions actually impair delusional belief formation just as they impair normal belief formation. Indeed the ‘best quality’ delusions, elaborated often with remarkable subtlety and accommodating all apparently disconfirmatory evidence, occur in the so-called monosymptomatic delusional psychoses in which there are no ancillary symptoms at all.

At best, therefore, the conventional function-based view fits the facts only rather awkwardly. The alternative action-based view, on the other hand, outlined above, fits the facts like a glove ([12], ch. 10). For this suggests, in relation to delusions, that the relevant failure is not in cognitive functioning but in what Aristotle called practical reasoning. Delusions, that is to say, should be understood as or in terms of impaired reasons for action. As a hypothesis this is consistent with the dual logical form of delusions: reasons for action, like delusions, take the form of assertions of fact and of expressions of value (eg., I turned right because, either, this is the way to Oxford, or, I ought to go to Oxford). Reasons for action, moreover, like delusions, depend on a background of ideas for their validity or invalidity: the status of ‘this is the way to Oxford’ as a reason for action depends on more than the (perceived) truth of the assertion. And the approach is consistent, finally, with the central place of delusions as

paradigm symptoms of mental illness. This is because actions are in part actually defined by the reasons for which they are done: my action *in* turning right *is* to head for Oxford. Hence while most failures of action are executive (there is an action but some difficulty in carrying it out, through indecision (obsession), fear (phobia), paralysis or whatever), with defective reasons for action there is in a sense no *action* at all.

The broader picture, the more complete view, provided by an action-based analysis of the medical concepts, thus suggests an account of delusions which is at least consistent with the broad outlines of their clinical psychopathology. As it stands, of course, such an account begs the question of what a defective reason for action might consist in. It is at just this point, however, that descriptive psychopathology, cast in action-failure terms, meshes with recent work in the philosophy of mind on the concept of action.

The potential two-way connections here are well illustrated by Searle's theory of Intentionality [11]. As a theory in the philosophy of mind this has all the right structural features to be compatible with action-failure accounts of the concept of mental illness. It is firmly anti-reductionist but without being anti-scientific. It is concerned with the logical nature of Intentional states. And it includes a rich and detailed account of actions, of the things people (characteristically) do – whether bodily and/or mental, active and/or passive – an account which brings out the complexity of the conceptual links between actions and beliefs.

Thus on Searle's account, beliefs are an important component of actions but they have only a secondary (Searle calls it an "aetiolated") Intentionality. Working backwards, actions are made up of bodily (or mental) movements together with intentions. (The initial lower case "i" indicates the everyday sense of intention, as in 'I intend to go to Oxford' – Searle distinguishes prior-intentions and intentions-in-action, it being the latter that are taken to be essential to actions). Then, secondly, beliefs, together with desires, and beliefs and desires of various kinds, are components of intentions. But, thirdly, there is also an additional component of intentions, what Searle calls Intentional Causation. For the very experience of performing an action includes the experience of 'causing', of 'making something happen' – it is this experience, as a component of the actual Intentional content of an intention, which marks off an action proper from merely accidental or coincidental ways in which that content may be satisfied (the 'deviant causal chains' noted below). Nonetheless, fourthly, beliefs, as Intentional states in their own right, depend on a complex set of conceptual elements. Beliefs are Intentional in that (i) they have an Intentional (or representational) content ('that p') in a particular psychological mode ('the *belief* that p' – compare 'desire that p' as an Intentional State with the same content in a different psychological mode); and (ii) their conditions of satisfaction are determined by their content (the state of the world *is* 'that p') with a

direction of fit which is governed by their psychological mode (mind-to-world in the case of belief, world-to-mind in the case of desire). In addition, beliefs, like other Intentional States are context dependent; they depend on a Network of other Intentional States and a Background of pre-Intentional capacities and stances to the world: the belief that 'I am going to Oxford' could not have this Intentional content in the absence of a Network of beliefs, about the nature of roads, the geography of England etc., and a Background of pre-Intentional states, such as the expectation that the steering wheel I am holding will normally remain solid.

It will be clear from this (incomplete) synopsis that Searle's model of belief and action contains many elements which in the case of delusional belief formation could be aberrant or defective. Conventional definitions of delusion (as either a false or unfounded belief) can be identified with Searle's account of belief itself as including an Intentional content with a mind-to-world direction of fit: delusion could thus be analysed in terms of *failure* of fit (false belief) or *accidental* fit (true belief). Indeed the determination with which delusions are sustained even against evidence which everyone else accepts, suggests an analysis in terms of reversal of the *direction* of fit, a delusional belief being satisfied (aberrantly) by a world-to-mind direction of fit where a mind-to-world direction of fit is appropriate. But delusions, as we have seen, may also take the form of value judgements, which, as an element of desire (as defined by Searle) would in the normal case have a world-to-mind direction of fit. Delusions, then, of both kinds, factual and evaluative, could involve a *reversal* of the normal direction of fit.

But the defect in delusional thinking, as we saw, seems to be in a putative background structure to the factual beliefs or value judgements in which they are expressed. This was suggested indirectly by the fact that delusions of both main (logical) kinds have identical implications: and directly by the existence of the paradoxical delusion of mental illness. Hence we are led, on Searle's model, to look for the defect in delusional thinking not in the belief (or desire) as such, but in the Intentional structures upon which beliefs (and desires) depend. This could be in the Network of Intentional States (the links could be defective, there could be disallowed connections, and so on) or perhaps in Searle's Background of pre-Intentional stances and capacities. Or we could go still deeper, to the connections between beliefs (and other Intentional states) and action. This is strongly suggested by accounts of illness in action-failure terms. For within such accounts delusions might involve defects, severally or together, in the experience of Intentional causation (integral, on Searle's account, to the Intentionality of action); in the relationship between beliefs, desires and other Intentional states, as components of intentions; in the connection, or direction of connection, between prior intentions and intentions-in-actions; or even in the

links between intentions of either kind and the bodily and/or mental movements with which they combine causally to form (basic) actions.

As an approach to the analysis of delusions all this has a degree of face-validity. There is something intuitively persuasive about the idea that delusions involve a failure of Intentionality: deluded patients, however logical and self-consistent, really do seem to suffer a break-down in the relationship between themselves and the world; there is something inherently mis-directed about delusional beliefs; delusions, like normal beliefs, are 'about things', but in a way which is somehow off-target. Then again, this approach, as against the conventional approach, is consistent with the central place of delusions as paradigm symptoms of mental illness. For actions, together with perceptions, are on Searle's account the primary forms of Intentionality, forms of which beliefs as such are merely aetiolated derivatives. Hence, if the pathology represented by delusions is in the Intentional structures by which beliefs are embedded in actions, then this pathology, too, will be primary pathology. There is a hint here, too, of why delusions should be so readily identifiable despite being obscure in meaning. For the Intentionality of actions and perceptions, as the primary forms of Intentionality, constitutes our most basic representational capacities, and thus underpins all our relationships not only with the world but with each other. Hence a strong intuitive ability to 'read' this Intentionality, whether it is normal in form or defective, is, literally, a condition of survival.

Still, suggestive as these possibilities may be, the approach, as described here, remains only an approach. It is a sketch of a framework for a pilot project! Yet this is as it should be. The relationship between normal belief and action is tricky enough to disentangle. The identification of (putative) defects in this relationship is bound to be no less tricky, involving as it must detailed clinical as well as philosophical research. And it is with such research that there could be returns for philosophy from descriptive psychopathology, as well as vice versa. Searle's theory certainly provides a rich resource of ideas for the development of our understanding of the nature of delusions. But the phenomenology of delusions, and of related psychotic symptoms, could provide an equally rich resource for testing and extending philosophical theory. Delusions are not discussed by Searle (though hallucinations are mentioned). Yet as Austin pointed out [15], there is often a good deal that we can learn about the normal by looking at the abnormal. Searle, along with many other philosophers in the Anglo-American tradition, proceeds by considering counter-examples. This helps to give depth and subtlety to his analysis. But the counter-examples employed are of a very limited, often trivial, kind. The 'deviant causal chains' standardly considered in this literature are a case in point: for example, raising my (paralysed) arm by trying so hard that I fall over, accidentally throwing a switch, which activates a powerful electromagnet, which happens to be above

me, and which causes my arm to go up by attracting my steel wrist watch [11]. There is nothing wrong with such cases in principle, of course. But there is a wealth of more substantial examples waiting to be explored in the day-to-day clinical phenomena of mental illness.

CONCLUSIONS

This paper may seem to have finished just as things were getting interesting. If so, it will have achieved its purpose. In tracing the parallels between the debate about mental illness and the mind-brain debate, the objective has been to bring the two areas into closer conjunction, and thus to spark off a potentially fruitful exchange of ideas between them. I have illustrated this here with an indication of the mutual significance of Searle's theory of Intentionality and recent work on the clinical concept of delusion. Clearly this is not exhaustive. Searle plans extensions of his theory to emotion and to human behaviour, both of which are directly relevant to descriptive psychopathology ([11], p. X). Equally, there are many pertinent areas of descriptive psychopathology other than delusion [43]. There are indeed many other kinds of abnormal belief besides delusion – obsessional beliefs, for example, and beliefs associated with phobic disorder. Beyond this, again, there are other theories of action: Dennett's 'Intentional Stance' [28], for instance, and Davidson's 'attributionism' [33] – the latter, indeed, brings Davidson in some ways closer than Searle to the emphasis on the importance of value judgements in recent work on the concepts of illness and disease. And there are, too, as noted in the Introduction, other relevant problems in the philosophy of mind. So there are all the ingredients here for a successful partnership between psychiatrists and philosophers, with delusions, perhaps, first on the research agenda.

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